### Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Signature of DFE

# Annual Return/Report of Employee Benefit Plan

This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), and 6058(a) of the Internal Revenue Code (the Code).

> ▶ Complete all entries in accordance with the instructions to the Form 5500.

OMB Nos. 1210-0110 1210-0089

2010

					Inspection	
Part I		tification Information				
For cale	ndar plan year 2010 or fiscal p	lan year beginning 02/01/2010		and ending 0	1/31/2011	
<b>A</b> This	return/report is for:	a multiemployer plan;	a multip	ole-employer plan; or		
		a single-employer plan;	a DFE	(specify)		
		_	_			
<b>B</b> This	return/report is:	the first return/report;	the fina	I return/report;		
		an amended return/report	; a short	plan year return/report (	less than 12 months).	
<b>C</b> If the	plan is a collectively-bargaine	d plan, check here				
<b>D</b> Chec	k box if filing under:	Form 5558;	automa	tic extension;	the DFVC program;	
2 000	. v s s s i i i i i i i i i i i i i i i i	special extension (enter d	lescription)			
Part	II Rasic Plan Inform	nation—enter all requested infor				
	ne of plan	cinci an requested into	madon		<b>1b</b> Three-digit plan 501	
	WN M RANCH CORP. HEALT	TH BENEFIT PLAN			number (PN) ▶	
					1c Effective date of plan	
<b>30</b> Dis-		Annalas and Change State and assets	1>		02/01/1998	
	i sponsor's name and address ress should include room or si	(employer, if for a single-employ	er pian)		<b>2b</b> Employer Identification Number (EIN)	
`	WN M RANCH CORP.				91-0823103	
					2c Sponsor's telephone	
					number 509-457-0990	
PO BOX			TATE ROUTE 821		2d Business code (see	
SELAH,	WA 98942	YAKIMA	A, WA 98901	instructions)		
					623000	
Caution	: A penalty for the late or inc	complete filing of this return/rep	oort will be assessed	d unless reasonable ca	use is established.	
	•				eport, including accompanying schedules,	
					nd belief, it is true, correct, and complete.	
SIGN	Filed with authorized/valid ele	ctronic signature.	07/26/2011	DENISE JUNT		
HERE	Signature of plan administ	rator	Date	Enter name of individ	dual signing as plan administrator	
	,					
SIGN						
HERE	Signature of employer/plar	n sponsor	Date	Enter name of individ	dual signing as employer or plan sponsor	
	<u> </u>	•			<u> </u>	
SIGN						
HERE			<del>- 1</del>	+		

Date

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.

Form 5500 (2010) v.092307.1

Enter name of individual signing as DFE

	Form 5500 (2010) Page <b>2</b>		
	Plan administrator's name and address (if same as plan sponsor, enter "Same")  NDOWN M RANCH CORP.		dministrator's EIN -0823103
	D BOX 217 ELAH, WA 98942	nı	dministrator's telephone umber 9-457-0990
4	If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, e the plan number from the last return/report:	nter the name, EIN and	4b EIN
а	Sponsor's name		4c PN
5	Total number of participants at the beginning of the plan year	5	152
6	Number of participants as of the end of the plan year (welfare plans complete only lines 6a, 6b, 6c, and	d 6d).	
а	Active participants	<u>6a</u>	147
b	Retired or separated participants receiving benefits	6b	0
С	Other retired or separated participants entitled to future benefits	6c	0
d	Subtotal. Add lines 6a, 6b, and 6c	6d	147
е	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	6e	
f	Total. Add lines <b>6d</b> and <b>6e</b>	6f	
g	Number of participants with account balances as of the end of the plan year (only defined contribution promplete this item)		
h	Number of participants that terminated employment during the plan year with accrued benefits that were	e	

Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item) .....

If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions:

(1)

(2)

(3)

(4)

(1)

(2)

(3)

(4)

(5)

(6)

**b** General Schedules

Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)

**b** If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristic Codes in the instructions:

6h

Code section 412(e)(3) insurance contracts

General assets of the sponsor

**H** (Financial Information)

A (Insurance Information)C (Service Provider Information)

I (Financial Information – Small Plan)

**D** (DFE/Participating Plan Information)

**G** (Financial Transaction Schedules)

**9b** Plan benefit arrangement (check all that apply)

Insurance

Trust

less than 100% vested.....

4A 4B 4D 4E 4L

a Pension Schedules

(1)

(2)

(3)

(4)

(1)

(2)

(3)

**9a** Plan funding arrangement (check all that apply)

Trust

Code section 412(e)(3) insurance contracts

MB (Multiemployer Defined Benefit Plan and Certain Money

Purchase Plan Actuarial Information) - signed by the plan

SB (Single-Employer Defined Benefit Plan Actuarial

Information) - signed by the plan actuary

General assets of the sponsor

R (Retirement Plan Information)

# **SCHEDULE A** (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

## **Insurance Information**

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

File as an attachment to Form 5500.

OMB No. 1210-0110

2010

For calendar plan year 2010 or fiscal plan year beginning 0201/2010 and ending 01/31/2011  A Name of plan SUNDOWN M RANCH CORP. HEALTH BENEFIT PLAN  Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.  1 Coverage Information:  (a) Name of insurance carrier  SUNLIFE ASSURANCE COMPANY OF CANADA  (b) EIN (c) NAIC code identification number of identification number of policy or contract year opposite year of policy or contract year opposite year of policy or contract year opposite year of the amount paid.  (a) Total amount of commission information. Enter the total fees and total commissions paid. List in item 3 the agents, brokers, and other persons in descanding order of the amount paid.  (a) Total amount of commissions paid (b) Total amount of fees paid (c) Amount of sales and base commissions paid (c) Amount (d) Purpose (e) Organization code (e) Organi	Pension Benefit Guaranty Co	orporation	Insurance companies ar pursuant to EF	This Form is Open to Public Inspection			
C Plan sponsor's name as shown on line 2a of Form 5500.  SUNDOWN M RANCH CORP.  D Employer Identification Number (EIN)  Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.  1 Coverage Information:  (a) Name of insurance carrier  SUNLIFE ASSURANCE COMPANY OF CANADA  (b) EIN (c) NAIC (d) Contract or identification number of persons covered at end of policy or contract year persons ov	For calendar plan year 20	10 or fiscal pla	an year beginning 02/01/2010	and e	ending 01/3	31/2011	
Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.  1 Coverage Information:  (a) Name of insurance carrier  SUNLIFE ASSURANCE COMPANY OF CANADA  (b) EIN		ORP. HEALTI	H BENEFIT PLAN		•	) •	501
Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.  1 Coverage Information:  (a) Name of insurance carrier  SUNLIFE ASSURANCE COMPANY OF CANADA  (b) EIN (c) NAIC code identification number policy or contract year (provide a lend of policy or contract year policy or contract year policy or contract year (provide a lend of policy or contract year policy or contract year policy or contract year (provide a lend of policy or contract year policy or contract year (provide a lend of policy or contract year policy or contract year (provide a lend of policy or contract year policy or contract year (provide a lend of policy or contract year policy or contract year (provide a lend of policy or contract year (provide a lend of policy or contract year policy or contract year (provide a lend of policy or contract year policy or contract year (provide a lend of policy or contract year policy or contract year (provide a lend of policy or contract year policy or contr							
Coverage Information:	•		ne 2a of Form 5500.	-	-	tion Number	(EIN)
(a) Name of insurance carrier SUN LIFE ASSURANCE COMPANY OF CANADA  (b) EIN (c) NAIC code identification number of identi	on a separat						
(e) Approximate number of persons covered at end of policy or contract year persons covered at end of policy or contract year persons covered at end of policy or contract year persons covered at end of policy or contract year persons covered at end of policy or contract year (f) From (g) To  38-1082080 80802 9264 146 02/01/2010 01/31/2011  2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in item 3 the agents, brokers, and other persons in descending order of the amount paid.  (a) Total amount of commissions paid (b) Total amount of fees paid 0  3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).  (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid WELLS FARGO INSURANCE SERVICES PO 80X 2547 YAKIMA, WA 98907  (b) Amount of sales and base commissions paid (c) Amount (d) Purpose (e) Organization code 1495  (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid (e) Organization code (c) Amount of sales and base commissions paid (c) Amount (d) Purpose (e) Organization code (e) Organization code	1 Coverage Information:						
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Code   identification number   persons covered at end of policy or contract year   (f) From   (g) To		(c) NAIC	(d) Contract or			Policy or c	ontract year
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(a) Total amount of commissions paid (b) Total amount of fees paid  1495  3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).  (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid  WELLS FARGO INSURANCE SERVICES  PO BOX 2547 YAKIMA, WA 98907  (b) Amount of sales and base commissions paid (c) Amount (d) Purpose (e) Organization code  1495  (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid  (b) Amount of sales and base commissions paid (c) Amount (d) Purpose (e) Organization code  (b) Amount of sales and base commissions paid (c) Amount (d) Purpose (e) Organization code	38-1082080	80802	9264	146	02/01/201	0	01/31/2011
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3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).  (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid  WELLS FARGO INSURANCE SERVICES  PO BOX 2547 YAKIMA, WA 98907  (b) Amount of sales and base commissions paid  (c) Amount  (d) Purpose  (e) Organization code  (b) Amount of sales and base and address of the agent, broker, or other person to whom commissions or fees were paid  (b) Amount of sales and base commissions paid  (c) Amount  (d) Purpose  (e) Organization code	(a) Total a	amount of com	nmissions paid	(b) ⊤	otal amount o	f fees paid	
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid  WELLS FARGO INSURANCE SERVICES  PO BOX 2547 YAKIMA, WA 98907  (b) Amount of sales and base commissions paid  (c) Amount  (d) Purpose  (e) Organization code  (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid  (b) Amount of sales and base commissions paid  (c) Amount  (d) Purpose  (e) Organization code  (b) Amount of sales and base commissions paid  (c) Amount  (d) Purpose  (e) Organization code			1495				0
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WELLS FARGO INSURANCE SERVICES  PO BOX 2547 YAKIMA, WA 98907  (b) Amount of sales and base commissions paid (c) Amount (d) Purpose  (e) Organization code  3  (b) Amount of sales and base commissions paid (c) Amount (d) Purpose  (e) Organization code  (b) Amount of sales and base commissions paid (c) Amount (d) Purpose (e) Organization code	g				sions or fees v	were paid	
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(c) Amount (d) Purpose (e) Organization code  (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid  (b) Amount of sales and base commissions paid  (c) Amount (d) Purpose (e) Organization code  (e) Organization code  (e) Organization code  (e) Organization code			TARIW	IA, WA 90907			
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid  (b) Amount of sales and base commissions paid  (c) Amount  (d) Purpose  (e) Organization code  3  (b) Amount of sales and base commissions paid  (c) Amount  (d) Purpose  (e) Organization code  (e) Organization code	<b>(b)</b> Amount of sales ar	nd base	Fees	and other commissions paid			
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid  (b) Amount of sales and base commissions paid  (c) Amount  (d) Purpose  (e) Organization code	commissions pa	id	(c) Amount	(d) Purpos	(e) Organization code		
(b) Amount of sales and base commissions paid  (c) Amount (d) Purpose (e) Organization code		1495					3
commissions paid (c) Amount (d) Purpose (e) Organization code		(a) Name	and address of the agent, broker, c	or other person to whom commiss	sions or fees v	were paid	
commissions paid (c) Amount (d) Purpose (e) Organization code							
commissions paid (c) Amount (d) Purpose (e) Organization code	(b) Amount of sales and base Fees and other commissions paid						
	` ,		(c) Amount	(d) Purpos	se		(e) Organization code

Schedule A (Form 5500)	2010	Page <b>2-</b>		
(a) No	me and address of the agent, broke	ar or other person to whom	commissions or foos were naid	
(a) Na	me and address of the agent, broke	er, or other person to whom	commissions of fees were paid	
(b) Amount of sales and base		Fees and other commission		(e) Organization
commissions paid	(c) Amount		(d) Purpose	code
(a) Na	me and address of the agent, broke	or other person to whom	commissions or fees were naid	
(a) Na	ine and address of the agent, bloke	ii, or other person to whom	commissions of fees were paid	
(b) Amount of sales and base		Fees and other commission		(e) Organization
commissions paid	(c) Amount		(d) Purpose	code
(a) Na	me and address of the agent, broke	er or other person to whom	commissions or fees were paid	
(a) No	and and address of the agent, prone	w, or other percent to whem	COMMISSIONIC OF 1000 WORD PAIG	
		Face and other commission	ao naid	
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commission	(d) Purpose	(e) Organization code
	(o) runount		(a) i dipoco	
<b>(a)</b> Na	me and address of the agent, broke	er, or other person to whom	commissions or fees were paid	
(b) Amount of sales and base		Fees and other commission	ns paid	(e) Organization
commissions paid	(c) Amount		(d) Purpose	code
	• •			
<b>(a)</b> Na	me and address of the agent, broke	er, or other person to whom	commissions or fees were paid	
(b) Amount of sales and base		Fees and other commission	ns paid	(e) Organization
commissions paid	(c) Amount		(d) Purpose	code

Pá	art II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	ridual contracts	with each carrier may	be treated	d as a unit for purposes of
4	Curre	ent value of plan's interest under this contract in the general account at year	end		4	
		ent value of plan's interest under this contract in separate accounts at year e			5	
		racts With Allocated Funds:				
	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount	nnection with th	ne acquisition or	6d	
		Specify nature of costs				
	е	Type of contract: (1) ☐ individual policies (2) ☐ group deferred (3) ☐ other (specify) ▶	d annuity			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan che	ck here		
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma		<u> </u>		
			ate participation	•		
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(2) Dividends and credits	. 7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		•				
	_	(6)Total additions			7c(6)	
	ď	Total of balance and additions (add <b>b</b> and <b>c(6)</b> )			7d	
		Deductions:				
		(1) Disbursed from fund to pay benefits or purchase annuities during year				
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	7e(3)			
		(4) Other (specify below)	7e(4)			
		•				
		(5) Total deductions			7e(5)	
		Balance at the end of the current year (subtract e(5) from d)			7f	

Page	4
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If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

Part III

**Welfare Benefit Contract Information** 

	a	Health (other than dental or vision)	b	Dental	С	Vision	C	Life insurance
	е	Temporary disability (accident and sickness)	f	Long-term disabilit	ty <b>g</b>	Supplemental unemp	loyment <b>h</b>	Prescription drug
	iΠ	Stop loss (large deductible)	ιĒ	HMO contract	k [	PPO contract		I Indemnity contract
	m X	Other (specify) ACCIDENTAL DEATH AND	DISN	MEMBERMENT	•	11 0 contract	,	I Indemnity contract
	· · · ·	Other (specify)						
9 1	- - -	ience-rated contracts:						
	•				00(1)			
		remiums: (1) Amount received 2) Increase (decrease) in amount due but unpaid			9a(1) 9a(2)			
		3) Increase (decrease) in amount due but unpaid						
		4) Earned ((1) + (2) - (3))					9a(4)	
	_ `	Benefit charges (1) Claims paid		i i	9b(1)		<b>σα</b> (¬)	
		2) Increase (decrease) in claim reserves						
	,	3) Incurred claims (add (1) and (2))					9b(3)	
		4) Claims charged				T .	9b(4)	
	,	Remainder of premium: (1) Retention charges (or				t	0.0(1)	
		(A) Commissions			9c(1)(A)			
		(B) Administrative service or other fees			9c(1)(B)			
		(C) Other specific acquisition costs			9c(1)(C)			
		(D) Other expenses			9c(1)(D)			
		(E) Taxes			9c(1)(E)			
		(F) Charges for risks or other contingencies			9c(1)(F)			
		(G) Other retention charges			9c(1)(G)			
		(H) Total retention					9c(1)(H)	
	(	2) Dividends or retroactive rate refunds. (These	amo	unts were paid in	cash, or	credited.)	9c(2)	
		Status of policyholder reserves at end of year: (1)		<u></u>	<u></u>	F	9d(1)	
		2) Claim reserves		•		<u>-</u>	9d(2)	
		3) Other reserves					9d(3)	
	e	Dividends or retroactive rate refunds due. (Do no	ot inc	ude amount entered	d in <b>c(2)</b> .)		9e	
10	Non	experience-rated contracts:						
	a <sup>-</sup>	Total premiums or subscription charges paid to c	arrier				10a	17413
		f the carrier, service, or other organization incurr		, ,		•		
		etention of the contract or policy, other than repo	orted	in Part I, item 2 abov	ve, report am	ount	10b	
	Spe	cify nature of costs						
Pa	rt IV	Provision of Information						
	rt IV		ation	nacassary to compl	ata Schodula	ΔΑ2 Π	Yes X	l No
11	Did	Provision of Information the insurance company fail to provide any inform a answer to line 11 is "Yes," specify the information			ete Schedule	A?	Yes X	No

### Form 5500

Department of the Treasury Internal Revenue Service

Department of Libbor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

### Annual Return/Report of Employee Benefit Plan

This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), and 6058(a) of the Internal Revenue Code (the Code).

> Complete all entries in accordance with the instructions to the Form 5500.

OMB Nos 1210-0110 1210-0089

2010

This Form is Open to Public

			Inspection
Part I Annual Report Identification Information			
	01/2010	and ending 017	31/2011
A This return/report is for: a multiemployer plan;	a multiple	employer plan; or	
a single-employer plan;	a DFE (sp	ecify)	
B This return/report is:  the first return/report;	the final re	eturn/report;	
an amended return/report;	a short pl	an year return/report (less than 12	months).
C If the plan is a collectively-bargained plan, check here			
D Check box if filing under: Form 5558;		extension;	the DFVC program;
special extension (enter des	cription)		
Part II Basic Plan Information—enter all requested informa	tion		A COLUMN CONTRACTOR DE LA COLUMN DE LA COLUMN COLUM
1a Name of planSundown M Ranch Corp. Health Bene	······································	1	<b>b</b> Three-digit plan 501
			number (PN)
		A contract of the contract of	C Effective date of plan
2a Plan sponsor's name and address (employer, if for a single-employer)	olan)	2	b Employer identification
(Address should include room or suite no.) Sundown M Ranch Corp.			Number (EIN) 91-0823103
Sundown w Kanch Corp.		2	C Sponsor's telephone
		-	number
			(509)457-0990
PO Box 217		2	!d Eusiness code (see instructions)
Selah	AW	98942	623000
2280 State Route 821			
	MA	98901	
Yakima		The Grant Control of the Control of	
Caution: A penalty for the late or incomplete filing of this return/report	t will be assessed u	inless reasonable cause is estat	olished.
Under penalties of perjury and other penalties set forth in the instructions, is statements and attachments, as well as the electronic version of this return	declare that I have our leads to the beautiful to the bea	examined this return/report, includit ast of my knowledge and belief, it is	ng accompanying schedules, strue, correct, and complete.
	l >= /		
sign ) June Sout	07/22/2011	THIL BENIECT	
HERE Signature of plan administrator	Date	Enter name of individual signing	as plan administrator
Signature or plan administrator			
SIGN SIGN	7 (22/2011	SCOTT MUNSO	*
HERE Signature of employer/plan sponsor	Date	Enter name of individual signing	as employer or plan sponsor
SIGN			
HERE Signature of DFE	Date	Enter name of Individual signing	as DFE
Signature of DFE	·		Form 5500 (2010)

v.092307.1

	Form 5500 (2010)	Page 2		
3a	Plan administrator's name and address (if same as plan sponsor, enter "Sam SAME"	ne")	3b Ac	Iministrator's EIN
				Iministrator's telephone umber
4	If the name and/or EIN of the plan sponsor has changed since the last return the plan number from the last return/report:	n/report filed for this plan, enter the name, EIN	and	4b EIN
а	Sponsor's name			4c PN
5	Total number of participants at the beginning of the plan year		5	152
6	Number of participants as of the end of the plan year (welfare plans complete	e only lines 6a, 6b, 6c, and 6d).		
а	Active participants		6a	147
b	Retired or separated participants receiving benefits		6b	0
С	Other retired or separated participants entitled to future benefits		6c	0
d	Subtotal. Add lines 6a, 6b, and 6c		6d	147
е	Deceased participants whose beneficiaries are receiving or are entitled to re-	ceive benefits	6e	
f	Total. Add lines 6d and 6e		6f	
g	Number of participants with account balances as of the end of the plan year complete this item)	•	6g	
h	Number of participants that terminated employment during the plan year with less than 100% vested		6h	
7	Enter the total number of employers obligated to contribute to the plan (only		7	
	If the plan provides pension benefits, enter the applicable pension feature coeffithe plan provides welfare benefits, enter the applicable welfare feature codes $4A$ $4B$ $4D$ $4E$ $4L$			
9a	Plan funding arrangement (check all that apply)	9b Plan benefit arrangement (check all that	t apply)	
	(1) X Insurance (2) Code section 412(e)(3) insurance contracts	(1) X Insurance (2) Code section 412(e)(3) i	nsuranc	e contracts

(3)		Trust	1	(3)	Ш	Trus	st	
(4)	X	General assets of the sponsor	İ	(4)	X	Gen	era	l assets of the sponsor
10 Check	all ap	plicable boxes in 10a and 10b to indicate which schedules are at	tache	d, and, w	here	indic	atec	d, enter the number attached. (See instructions)
a Pensi	on Sc	hedules	b	General	Sch	edule	es	
(1)		R (Retirement Plan Information)		(1)			H	(Financial Information)
(2)	-	MB (Multiemployer Defined Benefit Plan and Certain Money		(2)			0.002	(Financial Information - Small Plan)
• • •	ш	Purchase Plan Actuarial Information) - signed by the plan		(3)	X	1	Α	(Insurance Information)
		actuary		(4)	П		С	(Service Provider Information)
(3)	П	SB (Single-Employer Defined Benefit Plan Actuarial		(5)			D	(DFE/Participating Plan Information)
(0)		Information) - signed by the plan actuary		(6)			G	(Financial Transaction Schedules)